General

Guideline Title

ACR Appropriateness Criteria® assessment of gravid cervix.

Bibliographic Source(s)

Glanc P, Bhosale PR, Harris RD, Kang S, Pandharipande PV, Salazar GM, Shipp TD, Simpson L, Sussman BL, Wall DJ, Zelop CM, Javitt MC, Expert Panel on Women's Imaging. ACR Appropriateness CriteriaÂ® assessment of gravid cervix [online publication]. Reston (VA): American College of Radiology (ACR); 2014. 7 p. [40 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Glanc P, Andreotti RF, Lee SI, DeJesus Allison SO, Bennett GL, Brown DL, Dubinsky T, Javitt MC, Mitchell DG, Podrasky AE, Shipp TD, Siegel CL, Wong-You-Cheong JJ, Zelop CM, Expert Panel on Women's Imaging. ACR Appropriateness Criteria® assessment of gravid cervix. [online publication]. Reston (VA): American College of Radiology (ACR); 2011. 6 p. [48 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

ACR Appropriateness Criteria®

Clinical Condition: Assessment of Gravid Cervix

Variant 1: Patient: 16 to 24 weeks' gestation; at risk for preterm delivery, cervix <3 cm long; suggestion of funneling by transabdominal ultrasound examination; or postcerclage.

Radiologic Procedure	Rating	Comments	RRL*
Ultrasound (US) cervix transvaginal	9	Assess for change in cervical length several times over a 3 to 5 minute period. Record shortest closed cervical length. May add description of U-shaped or V-shaped funnel.	O
Rating Scale: 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate			*Relative Radiation

Radiologic Procedure	Rating	Comments	RRL*
		transvaginal ultrasound (TVU) is uncomfortable or unacceptably invasive. Record shortest closed cervical length. May add description of U-shaped or V-shaped funnel.	
US cervical stress test	7	This is a complementary study that may be performed in high-risk women with a normal TVU study. This procedure should not be performed in the setting of a dynamic cervix or short cervical length. It should be performed only in settings with provisions for labor and delivery. Record shortest closed cervical length. May add description of U-shaped or V-shaped funnel.	O
Rating Scale: 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate			*Relative Radiation Level

Summary of Literature Review

Introduction

Because preterm birth (PTB) is the major contributor to perinatal mortality and morbidity in the United States, the identification of women at risk for preterm delivery (<37 weeks' gestational age) is an important clinical priority. In the United States the overall frequency of PTB is 12.5%, of which two-thirds are spontaneous preterm birth (sPTB) and one-third are for obstetrical indications. Although the PTB <32 weeks represents only 1% to 2% of all deliveries, it accounts for 60% of perinatal mortality and almost 50% of long-term neurological morbidity.

Transvaginal ultrasound (TVU) is the study of choice for assessment of the gravid cervix. It is safe, well accepted by women, reproducible and widely available. Approximately 75% of women with asymptomatic cervical shortening will have a negative digital study, thus reinforcing the role of TVU in cervical assessment. Cervical functional or closed length (CL) is the single most reproducible and reliable parameter and furthermore is the single best predictor of PTB, with an inverse relationship between CL and the likelihood of PTB. Cervical length measurements before 14 weeks' gestation are limited and difficult to measure in a low-risk population because the cervix is not yet distinct from the lower uterine segment. Risk factors for short CL include congenital factors (collagen disease, Müllerian duct anomalies, diethylstilbestrol exposure, and biological variation), trauma during obstetrical delivery, gynecological manipulations (dilatation and curettage, dilation and extraction, hysteroscopy), or surgical treatment of cervical intraepithelial neoplasia. Shortening or effacement of the cervix begins at the internal cervical os and proceeds caudally. CL is not significantly modified by parity, race, or maternal body mass index.

A CL >25 mm is considered normal between 14 to 24 weeks' gestation. A normal CL has a high negative predictive value in high-risk women for PTB, which supports expectant management. Between 14 and 28 weeks the CL remains stable with a bell-shaped curve with the 50th percentile at 35 mm, 10th percentile at 25 mm, the fifth percentile at 20 mm, and the second percentile at 15 mm. The median cervical length is 40 mm prior to 22 weeks, 35 mm at 22 to 32 weeks, and 30 mm after 32 weeks. A CL below the 10th percentile is consistently associated with PTB; however, there is no single threshold value for subsequent development of PTB. A sonographic short cervix diagnosed by TVU is the most powerful predictor of PTB. Fifty percent of women with a CL <15 mm will deliver prior to 32 weeks. The earlier in gestation that a short CL is demonstrated, and the shorter the CL, the greater the risk of PTB. A short CL at 16 to 28 weeks has a strong association with PTB, and even more so if it occurs in a woman with a prior PTB or a woman who is earlier than 24 weeks.

Currently, one of the more controversial questions related to PTB is whether low-risk women with a singleton pregnancy should undergo a TVU CL screen at 22 weeks' gestation. Although there is insufficient evidence to recommend routine screening of asymptomatic pregnant women with TVU cervical length, 2 randomized controlled trials have shown a 35% to 45% reduction in PTB in women with cervical shortening <15-20 mm, who were treated with vaginal progesterone preparations. A recent meta-analysis of 5 trials of women treated with progesterone for asymptomatic midtrimester cervical shortening demonstrated a reduction of PTB up to 45% in women with a CL measurement ≤25 mm with no history of PTB. This suggests that a screening TVU CL in the second trimester (19 to 24 weeks) could be used to identify a group of women with a singleton pregnancy who would benefit from prophylactic progesterone to prevent sPTB. In a 2012 practice bulletin, the American College of Obstetricians and Gynecologists did not mandate universal CL screening in women without a prior history of PTB but also did not recommend against using such a screening strategy. Similarly, the Society for Maternal Fetal Medicine published recommendations that state that there is insufficient evidence to support a universal screening of CL; however, it is a reasonable practice for the individual physician to choose.

The role of cervical cerclage is less well-defined. A meta-analysis performed by a group of authors included the recommendation that cerclage

should be offered only to women with a history of PTB and CL ≤25 mm. Insertion of a cervical pessary has also demonstrated a variable decrease in the incidence of PTB. Ongoing research is needed to determine which of these options will be the most effective to decrease sPTB in pregnant women. In women with multiple gestations there is an increased risk of PTB but no evidence to support a specific intervention. Nonetheless, identification of a short cervix in this population may help guide interventions such as antenatal corticosteroid to promote lung maturation.

Imaging Modalities Overview

TVU is the gold standard for objective cervical assessment. TVU is considered safe in women who have documented premature rupture of membranes. It has limited ability to assess cervical softness or distensibility. It is recommended to observe the cervix for a minimum of 3 minutes to detect spontaneously occurring cervical shortening (also termed a dynamic cervix) and record the best shortest CL of the cervix. Shortest "best" closed CL is defined as "the technically most optimal of at least three separate measurements of the cervical length from the internal to the external os along the endocervical canal obtained in millimeters." Although funneling into the cervical canal is associated with a short cervix, it is not an independent predictor of PTB. If the patient cannot tolerate TVU, transperineal ultrasound (TPU) may be used. Transabdominal ultrasound is not considered reliable for cervical assessment. Initial studies on measuring CL by three-dimensional (3-D) ultrasound or magnetic resonance imaging have not demonstrated any measurable benefit as compared to CL TVU. Elastography is an investigational tool used to document the degree of cervical stiffness/softness which, in addition to cervical length, might constitute a complementary method of identifying cases at risk for preterm delivery. Promising investigational technologies for assessment of the gravid cervix, such as elastography or measures of collagen properties and organization, must be validated before clinical application.

Because most low-risk women with a midterm short CL do not deliver preterm, further research on risk assessment for sPTB is needed. Furthermore, the risk reduction for PTB in women with an intervention remains less than 50%. The corollary of this statement is that most PTBs occur in low-risk women with a normal cervical length at midtrimester.

Transvaginal Ultrasound

TVU CL is a safe, acceptable, reproducible technique that can provide high-quality measurements of the cervix. TVU is considered safe in women who have documented premature rupture of membranes. Early cervical changes associated with later PTB occur at the internal os, thus they can be detected early by TVU.

The evaluation should be performed with an empty bladder and without undue pressure on the anterior lip of the cervix, which can falsely elongate the cervix. This may be avoided by withdrawing the probe to ensure that the anterior and posterior lips of the cervix are of equal thickness. The image of the cervix should occupy at least 75% of the image and include the entire length of the cervix, from the internal cervical os to the external cervical os. A brief interval of 15 minutes between voiding and TVU may avoid focal myometrial contractions that can give the false impression of a longer cervix. There is no definitive recommendation on the time period for which the cervix should be monitored to detect spontaneous changes; however, monitoring for 3 minutes with a minimum of 3 measurements to obtain the shortest measurement of cervical length has been recommended. Additional measurements to describe the U-shaped or V-shaped funnel at the internal cervical os may be added. In a postcerclage patient it is often helpful to describe the CL in relationship to the cerclage sutures.

Transvaginal Ultrasound with a Cervical Stress Test

If the cervix remains normal in appearance, a "cervical stress test" can be applied to elicit a dynamic cervix. It is recommended that this maneuver only be carried out in locations with provisions for labor and delivery. If the cervix is already dilated, shortened, or dynamic in appearance, a cervical stress test should be avoided.

A cervical stress test is performed by either applying transfundal pressure while scanning transvaginally, or examining the patient during a Valsalva maneuver or coughing or while standing. Transfundal pressure is considered the most effective stress technique in eliciting cervical changes during the active assessment of the cervix. It is defined as applying moderate pressure on the maternal abdomen in the direction of the uterine axis for 15 seconds. A positive response is defined as any decrease in endocervical canal length accompanied by an increase in funnel width and length. It is important to monitor the cervical appearance for at least a couple of minutes after the maneuver as it may take time to elicit changes. Because some patients will initially have a completely normal-appearing cervix, these important maneuvers may identify additional women at risk for preterm labor. Only one best shortest closed CL measurement should be reported; thus, if the shortest length is after a cervical stress maneuver, then that measurement is reported.

Transperineal Ultrasound

The TPU method of cervical assessment is considered to be dependent on the experience of the sonographer, and failure to obtain an optimal image can occur in 0% to 12% of cases primarily due to shadowing by bowel gas or the pubic symphysis. If the external os is obscured by rectal gas, then maneuvers such as elevating the hips or clenching the buttocks may be helpful to dislodge rectal gas.

Although the overall mean length of the cervix on TVU is shorter by about 2 mm compared with TPU, in the clinically critical 14 to 20 week gestational age range the mean cervical length at TPU has been demonstrated to average 5.5 mm less than TVU. Moreover, when discrete pairs of cervical length measurements (the TPU and TVU measurements) were compared for individual patients, the mean absolute difference between these measurements was also 5.5 mm. Investigators who assessed the reliability of TPU in 3 gestational-age groups (10 to 14 weeks, 20 to 24 weeks, and 30 to 34 weeks) demonstrated that as the pregnancy progressed, the correlation between TVU and TPU measured CL became stronger, and the difference between the 2 methods became smaller. These studies suggest that TVU should be considered the optimal modality to image the cervix in most situations, in particular prior to 20 weeks. TVU may be avoided in women in whom amniotic membrane rupture is suspected or documented in order to avoid the theoretical risk of infection; however, this is not an evidence-based decision. In fact, several investigators have shown that a short cervical length is an independent risk factor for subsequent development of chorioamnionitis.

In summary, TPU should be reserved for and offered to women at increased risk for PTB but for whom TVU is unacceptably invasive or uncomfortable.

Transabdominal Ultrasound

Although most obstetrical sonographic examinations are performed transabdominally, this is less reliable than either TVU or TPU for evaluating the cervix. Using this approach, bladder overdistension as well as myometrial contractions can change the appearance of the lower uterine segment and cervix, creating a deceivingly normal appearance in women with cervical effacement, shortening, or frank dilatation. Furthermore, an underdistended bladder may preclude adequate cervical visualization for any one of a variety of reasons: acoustic shadowing from the pubic symphysis, refractive shadowing from the bladder-uterine interface, loss of the acoustic window provided by the urinary bladder and/or amniotic fluid, or an inability to manually displace the fetal head or other presenting part superiorly away from the lower uterine segment. Even when visible on a transabdominal scan, the cervical image may be suboptimal. Because the external os is often not clearly identified, a technically correct cervical length measurement may not be possible. Therefore, if a patient has a clinical history or sonographic findings suspicious for cervical pathology, consideration should be given to cervical scanning using a TVU approach. A recent study evaluated the threshold level for CL above which the risk for short CL on TVU is very low. Prevoid transabdominal CL ≤35 mm will detect 100% of TVU CL ≤20 mm with 41% specificity. To achieve this high sensitivity, 60% of patients required a TVU CL study.

Discussion of the Imaging Modalities by Variant

Variant 1: Patient: 16 to 24 Weeks' Gestation; at Risk for Preterm Delivery, Cervix <3 cm Long; Suggestion of Funneling by Transabdominal Ultrasound examination; or Postcerclage

TVU is the first method of choice. TPU may be performed in a patient in whom TVU is unacceptably invasive or uncomfortable. A cervical stress test may be applied if the cervix appears normal. If the cervix is dynamic or short, then it should not be performed. The cervical stress test should only be performed in settings where there are provisions for labor and delivery. If cervical length assessment is indicated, transabdominal examination may not be reliable, and performance of TVU or TPU is recommended.

Summary of Recommendations

- The risk of spontaneous preterm birth increases as cervical length decreases. The risk is highest when a short cervix is detected prior to 24 weeks' gestation.
- Cervical length below the 10th percentile (25 mm) between 16 and 28 weeks' gestation by TVU is consistently associated with an increased risk of spontaneous preterm birth.
- The single most reliable parameter and best predictor of preterm birth is a transvaginal measurement of closed cervical length. The shortest best measurement of closed cervical length should be reported.

Relative Radiation Level Designations

Relative Radiation Level*	Adult Effective Dose Estimate Range	Pediatric Effective Dose Estimate Range
O	0 mSv	0 mSv
☐	<0.1 mSv	<0.03 mSv
☐☐	0.1-1 mSv	0.03-0.3 mSv
☐☐☐	1-10 mSv	0.3-3 mSv
☐☐☐☐	10-30 mSv	3-10 mSv

*RRL assignments for some of the examinations cannot be made, because the actual patient doses in these procedures vary as a function of a

Relative Radiation Level*	Adult Effective Dose Estimate Range	Pediatric Effective Dose Estimate Range
30-100 mSv	10-30 mSv	

*RRL assignments for some of the examinations cannot be made, because the actual patient doses in these procedures vary as a function of a number of factors (e.g., region of the body exposed to ionizing radiation, the imaging guidance that is used). The RRLs for these examinations are designated as "Varies."

Clinical Algorithm(s)

Algorithms were not developed from criteria guidelines.

Scope

Disease/Condition(s)

Risk of preterm delivery in pregnancy

Guideline Category

Diagnosis

Evaluation

Prevention

Screening

Clinical Specialty

Obstetrics and Gynecology

Radiology

Intended Users

Advanced Practice Nurses

Health Plans

Hospitals

Managed Care Organizations

Physicians

Utilization Management

Guideline Objective(s)

To evaluate the appropriateness of various ultrasound modalities for the assessment of the gravid cervix

Target Population

Women at risk for preterm delivery

Interventions and Practices Considered

1. Ultrasound (US), cervix
    - Transvaginal
    - Transperineal
    - Stress test

Major Outcomes Considered

- Utility of radiologic examinations in measuring cervical length
- Risk of spontaneous preterm delivery

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Literature Search Summary

Of the 47 citations in the original bibliography, 10 were retained in the final document. Articles were removed from the original bibliography if they were more than 10 years old and did not contribute to the evidence or they were no longer cited in the revised narrative text.

A new literature search was conducted in July 2013 to identify additional evidence published since the *ACR Appropriateness Criteria® Assessment of Gravid Cervix* topic was finalized. Using the search strategy described in the literature search companion (see the "Availability of Companion Documents" field), 130 articles were found. Five articles were added to the bibliography. One hundred twenty-five articles were not used due to either poor study design, the articles were not relevant or generalizable to the topic, the results were unclear, misinterpreted, or biased, or the articles were already cited in the original bibliography.

The author added 21 citations from bibliographies, Web sites, or books that were not found in the literature search. Four citations are supporting documents that were added by staff.

See also the American College of Radiology (ACR) Appropriateness Criteria® literature search process document (see the "Availability of Companion Documents" field) for further information.

Number of Source Documents

Of the 47 citations in the original bibliography, 10 were retained in the final document. The new literature search conducted in July 2013 identified five articles that were added to the bibliography. The author added 21 citations from bibliographies, Web sites, or books that were not found in the literature search. Four citations are supporting documents that were added by staff.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Study Quality Category Definitions

Category 1 - The study is well-designed and accounts for common biases.

Category 2 - The study is moderately well-designed and accounts for most common biases.

Category 3 - There are important study design limitations.

Category 4 - The study is not useful as primary evidence. The article may not be a clinical study or the study design is invalid, or conclusions are based on expert consensus. For example:

a. The study does not meet the criteria for or is not a hypothesis-based clinical study (e.g., a book chapter or case report or case series description).
b. The study may synthesize and draw conclusions about several studies such as a literature review article or book chapter but is not primary evidence.
c. The study is an expert opinion or consensus document.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

The topic author assesses the literature then drafts or revises the narrative summarizing the evidence found in the literature. American College of Radiology (ACR) staff drafts an evidence table based on the analysis of the selected literature. These tables rate the study quality for each article included in the narrative.

The expert panel reviews the narrative, evidence table and the supporting literature for each of the topic-variant combinations and assigns an appropriateness rating for each procedure listed in the variant table(s). Each individual panel member assigns a rating based on his/her interpretation of the available evidence.

More information about the evidence table development process can be found in the ACR Appropriateness Criteria® Evidence Table Development documents (see the "Availability of Companion Documents" field).

Methods Used to Formulate the Recommendations

Expert Consensus (Delphi)

Description of Methods Used to Formulate the Recommendations

Rating Appropriateness

The American College of Radiology (ACR) Appropriateness Criteria (AC) methodology is based on the RAND Appropriateness Method. The appropriateness ratings for each of the procedures or treatments included in the AC topics are determined using a modified Delphi method. A series of surveys are conducted to elicit each panelist's expert interpretation of the evidence, based on the available data, regarding the appropriateness of an imaging or therapeutic procedure for a specific clinical scenario. The expert panel members review the evidence presented and assess the risks or harms of doing the procedure balanced with the benefits of performing the procedure. The direct or indirect costs of a procedure are not considered as a risk or harm when determining appropriateness. When the evidence for a specific topic and variant is uncertain or incomplete, expert opinion may supplement the available evidence or may be the sole source for assessing the appropriateness.

The appropriateness is represented on an ordinal scale that uses integers from 1 to 9 grouped into three categories: 1, 2, or 3 are in the category "usually not appropriate" where the harms of doing the procedure outweigh the benefits; and 7, 8, or 9 are in the category "usually appropriate"

where the benefits of doing a procedure outweigh the harms or risks. The middle category, designated "may be appropriate", is represented by 4, 5, or 6 on the scale. The middle category is when the risks and benefits are equivocal or unclear, the dispersion of the individual ratings from the group median rating is too large (i.e., disagreement), the evidence is contradictory or unclear, or there are special circumstances or subpopulations which could influence the risks or benefits that are embedded in the variant.

The ratings assigned by each panel member are presented in a table displaying the frequency distribution of the ratings without identifying which members provided any particular rating. To determine the panel's recommendation, the rating category that contains the median group rating without disagreement is selected. This may be determined after either the first or second rating round. If there is disagreement after the second rating round, the recommendation is "May be appropriate."

This modified Delphi method enables each panelist to articulate his or her individual interpretations of the evidence or expert opinion without excessive influence from fellow panelists in a simple, standardized and economical process. For additional information on the ratings process see the Rating Round Information document on the ACR Web site.

Additional methodology documents, including a more detailed explanation of the complete topic development process and all ACR AC topics can be found on the ACR Web site (see also the "Availability of Companion Documents" field).

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

Criteria developed by the Expert Panels are reviewed by the American College of Radiology (ACR) Committee on Appropriateness Criteria.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The recommendations are based on analysis of the current literature and expert panel consensus.

Summary of Evidence

Of the 40 references cited in the *ACR Appropriateness Criteria® Assessment of Gravid Cervix* document, 4 are categorized as well-designed therapeutic studies. Additionally, 36 references are categorized as diagnostic references including 1 well-designed study, 4 good quality studies, and 11 quality studies that may have design limitations. There are 20 references that may not be useful as primary evidence.

While there are references that report on studies with design limitations, 9 well-designed or good quality studies provide good evidence.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate selection of radiologic imaging procedures for evaluation and assessment of the grand cervix

Potential Harms

- Transvaginal ultrasound (TVU) may be avoided in women in whom amniotic membrane rupture is suspected or documented in order to avoid the theoretical risk of infection.
- If the cervix is already dilated, shortened, or dynamic in appearance, a cervical stress test should be avoided.
- The transperineal ultrasound (TPU) method of cervical assessment is considered to be dependent on the experience of the sonographer and failure to obtain an optimal image can occur in 0% to 12% of cases primarily due to shadowing by bowel gas or the pubic symphysis.

Relative Radiation Level

Potential adverse health effects associated with radiation exposure are an important factor to consider when selecting the appropriate imaging procedure. Because there is a wide range of radiation exposures associated with different diagnostic procedures, a relative radiation level (RRL) indication has been included for each imaging examination. The RRLs are based on effective dose, which is a radiation dose quantity that is used to estimate population total radiation risk associated with an imaging procedure. Patients in the pediatric age group are at inherently higher risk from exposure, both because of organ sensitivity and longer life expectancy (relevant to the long latency that appears to accompany radiation exposure). For these reasons, the RRL dose estimate ranges for pediatric examinations are lower as compared to those specified for adults. Additional information regarding radiation dose assessment for imaging examinations can be found in the ACR Appropriateness Criteria® Radiation Dose Assessment Introduction document (see the "Availability of Companion Documents" field).

Qualifying Statements

Qualifying Statements

An American College of Radiology (ACR) Committee on Appropriateness Criteria and its expert panels have developed criteria for determining appropriate imaging examinations for diagnosis and treatment of specified medical condition(s). These criteria are intended to guide radiologists, radiation oncologists, and referring physicians in making decisions regarding radiologic imaging and treatment. Generally, the complexity and severity of a patient's clinical condition should dictate the selection of appropriate imaging procedures or treatments. Only those examinations generally used for evaluation of the patient's condition are ranked. Other imaging studies necessary to evaluate other co-existent diseases or other medical consequences of this condition are not considered in this document. The availability of equipment or personnel may influence the selection of appropriate imaging procedures or treatments. Imaging techniques classified as investigational by the U.S. Food and Drug Administration (FDA) have not been considered in developing these criteria; however, study of new equipment and applications should be encouraged. The ultimate decision regarding the appropriateness of any specific radiologic examination or treatment must be made by the referring physician and radiologist in light of all the circumstances presented in an individual examination.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Identifying Information and Availability

Bibliographic Source(s)

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1999 (revised 2014)

Guideline Developer(s)

American College of Radiology - Medical Specialty Society

Source(s) of Funding

The American College of Radiology (ACR) provided the funding and the resources for these ACR Appropriateness Criteria®.

Guideline Committee

Committee on Appropriateness Criteria, Expert Panel on Women's Imaging

Composition of Group That Authored the Guideline

Panel Members: Phyllis Glanc, MD (*Principal Author and Panel Chair*); Priyadarshani R. Bhosale, MD; Robert D. Harris, MD, MPH; Stella Kang, MD; Pari V. Pandharipande, MD, MPH; Gloria M. Salazar, MD; Thomas D. Shipp, MD, RDMS; Lynn Simpson, MD; Betsy L. Sussman, MD; Darci J. Wall, MD; Carolyn M. Zelop, MD; Marcia C. Javitt, MD (*Specialty Chair*)

Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Glanc P, Andreotti RF, Lee SI, DeJesus Allison SO, Bennett GL, Brown DL, Dubinsky T, Javitt MC,

Mitchell DG, Podrasky AE, Shipp TD, Siegel CL, Wong-You-Cheong JJ, Zelop CM, Expert Panel on Women's Imaging. ACR Appropriateness Criteria® assessment of gravid cervix. [online publication]. Reston (VA): American College of Radiology (ACR); 2011. 6 p. [48 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Electronic copies: Available from the American College of Radiology (ACR) Web site .

Print copies: Available from the American College of Radiology, 1891 Preston White Drive, Reston, VA 20191. Telephone: (703) 648-8900.

Availability of Companion Documents

The following are available:

- ACR Appropriateness Criteria®. Overview. Reston (VA): American College of Radiology; 2015 Feb. 3 p. Electronic copies: Available from the American College of Radiology (ACR) Web site .
- ACR Appropriateness Criteria®. Literature search process. Reston (VA): American College of Radiology; 2015 Feb. 1 p. Electronic copies: Available from the ACR Web site .
- ACR Appropriateness Criteria®. Evidence table development – diagnostic studies. Reston (VA): American College of Radiology; 2013 Nov. 3 p. Electronic copies: Available from the ACR Web site .
- ACR Appropriateness Criteria®. Radiation dose assessment introduction. Reston (VA): American College of Radiology; 2015 Feb. 3 p. Electronic copies: Available from the ACR Web site .
- ACR Appropriateness Criteria® assessment of gravid cervix. Evidence table. Reston (VA): American College of Radiology; 2014. 19 p. Electronic copies: Available from the ACR Web site .
- ACR Appropriateness Criteria® assessment of gravid cervix. Literature search. Reston (VA): American College of Radiology; 2014. 1 p. Electronic copies: Available from the ACR Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on December 28, 2000. The information was verified by the guideline developer on January 25, 2001. This summary was updated by ECRI Institute on June 15, 2009. This summary was updated by ECRI Institute on March 9, 2012. This summary was updated by ECRI Institute on July 29, 2015.

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